DOE F 350.6
(08-02)

OMB Control No: 1910-5120
Expiration Date: 8/31/05

**Work History for Claim Under**
Energy Employees Occupational Illness Compensation Program Act Part D-
DOE State Workers' Compensation Assistance Program

**U.S. Department of Energy**
Office of Environment Safety and Health
Office of Worker Advocacy

## EMPLOYEE INFORMATION

| Print Name | Social Security Number |
|---|---|
| _____<br>Last First M.I. | \|__\|__\|__\|-\|__\|__\|-\|__\|__\|__\|__\|<br>Date of Birth: _____/_____/_____ |
| Former Name (e.g. maiden name/legal name change/other)<br>_____<br>Last First M..I. | Employee Number(if known)<br>\|_____\| |

In the following section, list the complete employment history of the employee named above in chronological order. Begin with the most recent period of employment. If you require additional space to explain or clarify any point, attach a supplemental statement to this form.

## EMPLOYER 1

| Dates of Employment | Start Date / / | End Date / / |
|---|---|---|

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness.

Was a dosimetry badge worn while employed?

☐ Yes Dosimetry Badge Number, if known \|_____\| ☐ No

☐ Unknown

## EMPLOYER 2

| Dates of Employment | Start Date / / | End Date / / |
|---|---|---|

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness.

Was a dosimetry badge worn while employed?

☐ Yes Dosimetry Badge Number, if known |_____| ☐ No
☐ Unknown

## EMPLOYER 3

| Dates of Employment | Start Date / / | End Date / / |
|---|---|---|

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness.

Was a dosimetry badge worn while employed?

☐ Yes Dosimetry Badge Number, if known |_____| ☐ No

☐ Unknown

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## EMPLOYER 4

| Dates of Employment | Start Date / / | End Date / / |
|---|---|---|

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness.

Was a dosimetry badge worn while employed?

☐ Yes Dosimetry Badge Number, if known |_____| ☐ No

☐ Unknown

## DECLARATION OF PERSON COMPLETING FORM

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain assistance as provided under EEOICPA Part D or who knowingly accepts assistance or compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by fine or imprisonment or both.

I affirm that the employment history provided on this form is accurate and true.

Signature_____Date_____